An Independent Licensees of the Blue Cross and Blue Shield Association.

Your Health**Profile**

for individuals or businesses with 1 to 9 employees

Thank you for completing this Health Profile so we can provide a Custom Quote for your health insurance.

Section 2 asks questions about health conditions. Don't be overly concerned about answering "yes" to a question. A "yes" doesn't automatically disqualify you from coverage. Remember to mark "yes" *only if medical service for the listed condition has been received in the last 5 years,* then give details in Section 3.

Please include complete information for each person in your family wanting health insurance. An incomplete Health Profile may need to be returned for more information and delay your quote.

Your Health Profile Is Confidential. Only authorized Blue Cross and Blue Shield of Kansas employees have access to your information. When you have completed this questionnaire, please return in the envelope provided. Thank you.

Individuals and Families
Send completed Health Profile to:
Blue Cross and Blue Shield of Kansas
PO Box 517
Topeka, KS 66601
Fax: 785-290-0716

Employers
Send completed Health Profile to:
Blue Cross and Blue Shield of Kansas
PO Box 518
Topeka, KS 66601
Fax: 785-290-0719

HealthProfile

For individuals and businesses with one to nine employees

For office use only

Sys. Number | Rep. Number | Date

Business Name

Section 1

I understand that completing this form in **no way obligates me to purchase coverage**. I will complete the information below for each person requesting coverage. I understand all information is kept confidential.

Please answer all of the following questions for each person interested in coverage.

Name ______ Last ______ First ______ MI

Residential Address ______ Street

______ City ______ County ______ State ______ ZIP Code + 4

Mailing Address ______ Street/P.O. Box
if different from residential address

______ City ______ State ______ ZIP Code + 4

Home Phone (______ Area Code)______ Daytime Phone (______ Area Code)______

Cell Phone (______ Area Code)______ Fax (______ Area Code)______

Married? ☐ Yes ☐ No Date of marriage ______ MM / ______ DD / ______ YYYY Email Address ______

Has anyone listed below gained entry to the U.S. through a VISA? If so, who and what type? ______

Applicant

Social Security No. ______

Date of Birth ______ MM / ______ DD / ______ YYYY Gender ☐ Male ☐ Female Height ______ Weight ______

Spouse Name ______ Last ______ First ______ MI

Social Security No. ______

Date of Birth ______ MM / ______ DD / ______ YYYY Gender ☐ Male ☐ Female Height ______ Weight ______

Dependent must be under age 26 and a dependent either naturally, through adoption, as a stepchild or you must have legal guardianship* or legal custody*. (*not eligible for life insurance.)

Dependent Name ______ Last ______ First ______ MI

Social Security No. ______ Relationship to Applicant ☐ Child ☐ Stepchild ☐ Legal guardian ☐ Legal custody

Date of Birth ______ MM / ______ DD / ______ YYYY Gender ☐ Male ☐ Female Height ______ Weight ______

Dependent Name ______ Last ______ First ______ MI

Social Security No. ______ Relationship to Applicant ☐ Child ☐ Stepchild ☐ Legal guardian ☐ Legal custody

Date of Birth ______ MM / ______ DD / ______ YYYY Gender ☐ Male ☐ Female Height ______ Weight ______

Dependent Name ______ Last ______ First ______ MI

Social Security No. ______ Relationship to Applicant ☐ Child ☐ Stepchild ☐ Legal guardian ☐ Legal custody

Date of Birth ______ / ______ / ______ Gender ☐ Male ☐ Female Height ______ Weight ______

Section 2

yes	no	
		Please check the boxes "yes" or "no". For each answer marked "yes", circle the condition and explain in Section 3 below:
☐	☐	**1. Do you or any dependent currently smoke?** If yes, who? ____________
		2. Have you or any other person(s) to be insured been diagnosed or treated for any of the following **in the past 5 years:**
☐	☐	a. heart or circulatory problems?
☐	☐	b. high blood pressure? (If yes, **please provide average of last 3 readings** _____/_____)
☐	☐	c. lungs or respiratory problems?
☐	☐	d. disorders of the kidneys or reproductive organs?
☐	☐	e. disorder of the liver, gallbladder, intestines, rectum, stomach or other vital organs?
☐	☐	f. diabetes or high blood sugar? If yes, **please provide A1C reading** ________
☐	☐	g. neurological disorder, stroke, physical incapacitation or seizures? If yes, **date of last seizure** ________
☐	☐	h. immune deficiency disorder or AIDS/AIDS-related complex?
☐	☐	i. cancer or malignancy?
☐	☐	j. blood, gland or skin problems?
☐	☐	k. arthritis, paralysis, disease or disorder of the muscles, bones or joints?
☐	☐	l. disorder of the esophagus, throat, nose or eyes (not to include eye glasses or contact lenses)?
☐	☐	m. alcoholism or other drug/substance dependency?
☐	☐	n. depression, anxiety, or any mental/nervous condition?
		3. In the past five years have you or any person to be insured:
☐	☐	a. consulted a health care provider, received treatment at a hospital or other medical facility or been advised to have treatment for **any other condition not listed**?
☐	☐	b. used any narcotics or controlled substances, except as legally prescribed by a physician?
☐	☐	c. taken a prescription drug for a continuous 30-day or more time period? (include treatment dates below)
☐	☐	**4.** Are any of the persons listed pregnant?
☐	☐	**5.** Are you or any dependent disabled or aware of any condition that has prevented you or any dependent from receiving health, life or accident insurance in the past 5 years?

Section 3

Explain conditions in detail for any "yes" responses in section 2. Omitted information may cause delays. If additional space is needed, please attach a separate sheet.

Question no.	Person treated	Diagnosis or details about condition, treatment, medication name & dosage	Date diagnosed/ treated	Date physician last seen	Is further treatment recommended? (please explain)	Physician name, city and state
					☐ yes ☐ no	
					☐ yes ☐ no	
					☐ yes ☐ no	
					☐ yes ☐ no	
					☐ yes ☐ no	

Section 4

Important Information

Please read the following important statements and **sign below to complete your health profile.**

- I understand that Blue Cross and Blue Shield of Kansas, Inc. (BCBSKS) will re-rate, terminate or rescind the contract for the following conditions: 1) if the information received from future claims or supporting records within two years after the date the contract becomes effective indicates information provided on this health profile was incorrect; 2) if such information received at any time indicates the information provided in this health profile intentionally misrepresented a material fact or was fraudulent. **Rescinding only pertains to individual/non-group contracts and is not applicable to group contracts.**
- For Advance Insurance Company of Kansas (AICK), no misrepresentation made in obtaining or securing a policy of insurance on the life or lives of any person or persons, citizens of this state, shall be deemed material or render the policy void unless the matter misrepresented shall have actually contributed to the contingency or event on which the policy is to become due and payable. Any dependents obtained through legal guardianship or legal custody are not eligible for life insurance.
- I understand no representative of BCBSKS or AICK has the authority to waive any information required on this health profile; or to bind BCBSKS to provide coverage for me or any of my dependents or to waive, alter or change the provisions of the contract which may be issued.
- I understand that my signature verifies that I have read all of the information on this form and represent that all statements made herein are complete and true to the best of my knowledge. I understand BCBSKS or AICK shall have no liability for payment of services until all of the following occur: 1) the enrollment form has been received and approved, 2) an official contract has been issued and delivered, and 3) the full first premium has actually been paid to and accepted by BCBSKS or AICK.
- **I understand all coverage is subject to the health of all applicants on this health profile remaining unchanged to the effective date of coverage. If any change in health occurs before the effective date of coverage, I understand I must notify the BCBSKS Underwriting Department at 1-800-432-0216. (A photographic copy of this authorization shall be as valid as the original.)**

Authorization for the Release of Protected Health Information:

- I understand that by signing this health profile, I authorize the disclosure of all health information by any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, other health care provider, insurance company, or any other organization or person who has provided payment, treatment, or services to me or on my behalf or to any of my dependents covered by this health profile or on their behalf, to BCBSKS or AICK.
- I understand that the information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and will no longer be protected by federal privacy regulations.
- I further understand that by signing this health profile, I authorize BCBSKS to disclose any and all health information they possess or obtain about me or about my dependents covered by this health profile to AICK for the purpose of determining initial or continuing eligibility for coverage and that BCBSKS conditions payment, enrollment, and eligibility of benefits on my authorizing such disclosures.
- This authorization is valid for a period no greater than 2 years or until the termination of health insurance coverage with BCBSKS or until such time as written revocation is received by BCBSKS. I understand that revocation of this authorization will not affect any action taken in reliance upon this authorization before the written revocation was received.

Your signature required ______________________________ Date ____/____/____

(Signature of parent/guardian required if applicant(s) under age 18)

Print Your Name ______________________________

This information is being furnished in compliance with applicable federal regulations.

This Notice has important information. This notice has important information about your application or coverage through Blue Cross and Blue Shield of Kansas. Look for key dates in this notice. You may need to take action by certain deadlines to keep your health coverage or help with costs. You have the right to get this information and help in your language at no cost. Please call 1-800-432-3990.

Discrimination is against the law.

Blue Cross and Blue Shield of Kansas (BCBSKS) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. BCBSKS does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Blue Cross and Blue Shield of Kansas:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact Holly Graves.

If you believe that BCBSKS has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Holly Graves, Director, Individual Sales and Customer Service, 1133 S.W. Topeka Blvd., Topeka, KS 66629-0001,
1-800-432-3990, TTY: 1-800-766-3777, Fax: 785-290-0711, CSC@bcbsks.com.

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Holly Graves is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Para obtener asistencia en español, llame al servicio de atención al cliente al número que aparece en su tarjeta de identificación.

請撥打您 ID 卡上的客服號碼以尋求中文協助。

Gọi số dịch vụ khách hàng trên thẻ ID của quý vị để được hỗ trợ bằng Tiếng Việt.

한국어로 도움을 받고 싶으시면 ID 카드에 있는 고객 서비스 전화번호로 문의해 주십시오.

Para sa tulong sa Tagalog, tumawag sa numero ng serbisyo sa customer na nasa inyong ID card.

Обратитесь по номеру телефона обслуживания клиентов, указанному на Вашей идентификационной карточке, для помощи на русском языке.

اتصل برقم خدمة العملاء الموجود على بطاقة هُويتك للحصول على المساعدة باللغة العربية.

Rele nimewo sèvis kliyantèl ki nan kat ID ou pou jwenn èd nan Kreyòl Ayisyen.

Pour une assistance en français du Canada, composez le numéro de téléphone du service à la clientèle figurant sur votre carte d’identification.

Ligue para o número de telefone de atendimento ao cliente exibido no seu cartão de identificação para obter ajuda em português.

Aby uzyskać pomoc w języku polskim, należy zadzwonić do działu obsługi klienta pod numer podany na identyfikatorze.

日本語でのサポートは、ID カードに記載のカスタマーサービス番号までお電話でお問い合わせください。

Per assistenza in italiano chiamate il numero del servizio clienti riportato nella vostra scheda identificativa.

Rufen Sie den Kundendienst unter der Nummer auf Ihrer ID-Karte an, um Hilfestellung in deutscher Sprache zu erhalten.

برای دریافت راهنمایی به زبان فارسی ، با شماره خدمات مشتری که بر روی کارت شناسایی شما درج شده است تماسبگیرید..